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A qualitative study of the understanding and use of 'compassion focused coping strategies' in people who suffer from serious weight difficulties

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Abstract

Background: The physical and psychological health problems associated with obesity are now well documented, as is the urgency for addressing them. In addition, associations between quality of life, depression, self-esteem, self-criticism, and obesity are now established indicating a need for a better understanding of the links between self-evaluation, affect-regulation and eating behaviours.

Methods: Compassion has now been identified as a major source of resilience, helpful self-relating and affect regulation. Thus this study used semi-structured interviews to explore the understanding and experiences of compassion in 2 overweight men and 10 women seeking help for weight problems. The interviews examined people's understandings of compassion, their recall of experiences of compassion in childhood, their current experiences of receiving compassion from others, being compassionate to others, being self-compassionate, and whether they would be compassionate or self-critical for relapses in overeating. Interviews were transcribed and analysed using thematic analysis (*Qual Res Psychol*, **3:**77-101, 2006).

Results: Participants saw compassion as related to 'caring' and being 'listened to'. However, their recall of earlier experiences of compassion was of primarily practical help rather than emotional engagement. Typically their response to their own relapse and setbacks were self-criticism, self-disgust and even self-hatred rather than self-caring or understanding. Self-critical/hating responses tend to be associated with poor weight regulation.

Conclusions: When people with weight problems relapse, or struggle to control their eating, they can become quite self-critical, even self-hating, which may increase difficulties with emotionally coping and maintaining healthy lifestyles and eating habits. Although turning to others for support and compassion, and becoming self-compassionate are antidotes to self-criticism, and are associated with better coping and mental health, many participants did not utilise compassionate strategies – often the opposite. It is possible that interventions that include mindfulness and compassion training could be helpful for these difficulties.

Keywords: Compassion, Coping strategies, Obesity, Relapse, Shame, Thematic analysis, Weight

Background

Overweight is a prelude to obesity [1]. The secular trend of increased obesity prevalence is getting worse [2] and projected trends for children paint a worrying picture [3]. Predictions of the secular trend in obesity suggest that 60% of the UK population will be obese by 2050 This is estimated to add £45.5 billion per year to the UK national health budget [2] due to the associated chronic, long-term ill-health problems such as heart disease, stroke, cancer and diabetes [2-6]. Overweight, obesity and the attendant health problems are therefore major issues for governments, the food industry, consumers and of course health professionals to address.

Against this background there has been an increasingly urgent interest in helping people navigate towards personally focused dietary, lifestyle and other solutions

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to obesity. Encouraging people to partake in healthier behavioural choices creates a foundation of healthy habits that lead to greater wellbeing, quality of life and reduced healthcare expenditure. However, changes in diet and activity patterns per se are the mechanics of behaviour change; they are what people do to alter their energy balance. Of equal importance are the motivators and emotional drivers of behaviour change.

The causes of obesity are multi-factorial involving genetic, social, psychological and environmental factors. The current ready availability of energy dense, high fat, sugar-rich foods predispose humans to weight gain, given that we have evolved to bank surplus energy in periods of abundance to protect ourselves from environmental uncertainties in the supply of energy and nutrients, and early human expended energy seeking food sources [7]. Pre-packaged foods such as pizzas, crisps, beef-burgers and chocolate cakes are of very recent origin. Psychosocial stress, and the neurophysiology underpinning stress, may also be involved in predisposing humans to overeating and weight gain [1,8]. Stressful early life experiences, such as physical and verbal abuse, also play a role in how people handle stress and weight gain [1]. Some people use certain foods to help regulate stress-induced, difficult emotions [9]; and indeed increased eating is a common outcome of stress, especially work stress [10] with potential gender differences on the types of stress linked to weight [5,6].

Foods are also directly linked to emotion regulation [10]. Indeed, from an early age children can be given energy dense, high-fat and high sugar foods when distressed to act as pacifiers, and people may grow up associating foods with a range of social outcomes and emotional consequence. Food is used to celebrate and reward but can also be a source of comfort and distraction from emotion. Goss and Gilbert [11] and Goss and Allan [12] reviewed the literature showing that many people with eating difficulties and disorders can use food to try to regulate complex emotions, such as anger, anxiety, depression, shame and loneliness and try to feel in control. Lehman and Rodin [13] found that binge eaters tended to use food as a way to comfort and sooth the self. There is also increasing evidence that people with weight problems struggle to recognise, understand or process their emotions. Indeed, alexithymia has recently been shown to be linked to obesity further contributing to the use of food as an emotional regulator [14]. For some people impulsive and 'thoughtless' eating is a common difficulty, which is why mindfulness can be helpful [15].

The roles of shame and self-criticism in eating regulation

Although we have created an environment of easily available, energy dense high-fat, high sugar foods, which predisposes us to weight gain, with most commentators recognising that a change in food production and supply partly fuels the obesity epidemic; [7], it is nonetheless usually individuals who carry the burden of blame for weight gain. Indeed, multiple lines of evidence suggest that obese people experience stigma in the domains of employment, education and health care [16-20]. Prejudice and stigma enhance psychosocial stress and undermine physical and mental well-being [17,21]. In a recent, major study of 2,944 men and women under the age of 50 Jackson et al. [22] found that weight discrimination and weight stigma was stressful and counter-productive in helping people lose weight. In fact, weight discrimination and stigma were positively associated with 'waist circumference and weight status'.

Social stigma also generates emotions of shame and self-criticism [23]. Shame can even exist when people have lost weight [24]. The pain of shame and criticism from others can greatly disrupt a person's ability to control their weight partly because these emotions increase aversive emotions and self-criticism [23,25], for which food can seem a pacifier and distractor [12,26].

It might be thought that the threat and unpleasantness of shame-based self-criticism would be a helpful way to bring eating under control but in fact it makes things worse. The reasons for this are slightly counterintuitive. In a landmark study, Herman and Mack [27] found that individuals who make attempts to restrict their eating often end up eating more when given calorific preloads. They termed this *counter-regulation* and various hypotheses have been put forward to explain why some individuals, who want to lose weight, actually end up eating more when given, or told they were given, high calorie foods. This tendency seems especially true for those with low self-esteem, indicating again that food may have been used to cope with negative self-emotions. To further explore the link between eating and negative self-emotion, Heatherton et al. [28] explored eating behaviours after failure events in people who were and were not attempting to diet. They found that failure events tended to increase food intake in dieters, suggesting that, for these subjects at least, food may be used as an affect regulator. In addition, when some dieters feel that they have broken their regimes in some way they can perceive themselves as failures and become self-critical rather than self-reassuring or self-supportive [26].

In fact, shame and self-criticism are known to be linked to a range of psychological difficulties [29] including all forms of eating disorder [30]. Contrary to the basic belief that if you criticise or threaten people they will then be motivated to change and improve, the evidence shows that shame and self-criticism *do not* inspire adaptive behaviours that increase well-being, often quite the reverse [23,29]. Indeed, shame and self-criticism are especially associated with binge eating disorder [31] and obesity [32]. In a study of eating disorders Birgegard et al. [33] found

that anorexia was associated with self-control and dominant-submissive themes whereas bulimia was especially associated with self-hate.

Whilst shame and self-criticism may actually increase the tendency to use food and overeat as an emotion regulation strategy, kindness, support and compassion from others [34] and self-compassion [25,35,36] may offer new emotion regulation opportunities [25,37] especially for people with eating difficulties [12]. Self-compassion (being kind, understanding and encouraging to oneself in times of difficulty) is associated with more positive body image, self-directed thoughts and feelings [38,39]. Webb and Forman [40] found that self-compassion was associated with lower tendencies for binge eating in college women. Adams and Leary [26] gave college women an unhealthy food preload but taught one group to switch to self-compassion when they noticed self-criticism. The self-compassion group (compared to the control group) showed less distress and lower subsequent eating. Indeed, there is growing evidence that developing affiliative relationships with oneself and others is highly beneficial to mental health and affect and behavioural regulation in general [41] and compassion focused approaches to eating have now been developed for self-help [42].

The role of compassion

Compassion is commonly defined as a 'sensitivity to suffering of self and others with a commitment try to alleviate and prevent it.' [37,43,44]. It is related to the evolved psychology of caring behaviour [45]. Affiliative and caring/ compassionate behaviour has a range of physiological and psychological effects on both givers and receivers [41]. Genuine compassion means a preparedness to engage with the nature of suffering, and the causes of suffering, and having the wisdom to offer helpful interventions; to do things that address it. Compassion is deeply relational in that we can be compassionate to others, be open and receptive to compassion from others, and be self-compassionate. All these are significantly associated with each other; e.g., people who have received little affiliative or compassionate care from others can struggle with being open to compassion or self-compassionate [25]. This is important because receiving compassion and self-compassion are often the antidotes to shame, self-criticism and self-disliking and are associated with a buffering of mental health problems [34,35]. While compassion is rooted in the evolution of basic caring behaviour [25,46] not all "efforts at caring behaviour" are compassionate. Trying to reduce inner distress might seem a compassionate motive but not if this is with binge drinking or eating.

Our experience of caring therefore varies as to how compassionate it actually is. Koren-Karie et al. [47] explored three types of maternal interaction: Positively insightful, one-sided, and disengaged. Positively insightful mothers try to see their child's experiences through the *child's eyes*, and accounting for them being a child and taking an interest in their feelings. The one side-mother is keen to care for her child but has preset ideas of what a child needs and an 'undimensional' view of the child, tends to impose care rather than empathically work out feelings with the child and offer practical rather than emotional support. Disengaged mothers are characterized by a lack of emotional involvement. Even thinking about what might be going on in their child's mind was novel to them and difficult. So compassion is complex and involves a genuine motivation to be caring, attention sensitive, sympathetic and empathic with capacities to mentalize and be tolerant of distress in self and others [25,48]. We raise these issues as they offer a context for the study undertaken here.

Our knowledge of compassionate processes for people wishing to lose weight are therefore limited and we have to question whether or not the recent developments in compassionate approaches to eating are actually required.

Aims

The aims of this study were to develop a qualitative investigation into:

1. How people with weight problems that are seeking treatment for weight loss see and understand compassion and the value of compassion.
2. Experiences of compassion in childhood and current experiences of compassion, both towards themselves and others reported by people seeking treatment for weight loss.
3. Do people use compassionate/ self-compassionate strategies to address difficulties in adhering to weight loss treatment?
4. What is the potential role of self-compassion in the treatment of people seeking treatment for weight loss?

Aim 1 relates to areas 1–2 on the interview schedule; aim 2 relates to questions 2–5; aim 3 relates to questions 6–7 and aim 4 is a synthesis of all 7 questions.

Method

Study design

As there was no previous research specifically investigating compassion and obesity, an exploratory, qualitative approach was adopted for the study. Qualitative research focuses on the phenomenological experiences of individuals. This phenomenological perspective involves a focus on the *life world* of the participants and their ability to be open with and about their experiences and beliefs [49]. Elliott et al. [50] have pointed out that, "qualitative research methods lend themselves to understanding

participants' perspectives, to defining phenomena in terms of experienced meanings and observed variations, and developing theory for field work." (p. 216). Semi-structured interviews were conducted in order to explore experiences of compassion in people who were obese.

The study was reviewed and approved by the local research ethics committee and the relevant NHS research governance departments.

Participants

Participants were recruited from a diabetic clinic, a bariatric clinic and a GP surgery. 12 participants agreed to take part in the study. The participants were aged between 38 and 70 years (average = 54 years); there were two male and 10 female participants. BMIs were not taken due to privacy/shame issues and because these were not the focus of this study.

Data collection

The interview schedule was developed by Paul Gilbert and Corinne Gale as part of her PhD [51] according to recommendations for semi-structured interviews [52], with consultation from colleagues in the field, and based on research in the area of compassion [53]. The interview schedule covered the following areas:

1. Participants' understanding of 'compassion'
2. Experiences of compassion towards others
3. Experiences of compassion from others
4. Experiences of compassion towards the self
5. Experiences of compassion in childhood
6. Participants' responses to a relapse in their eating difficulties
7. Participants' responses to others facing a relapse in their eating difficulties

The interviews were arranged at a time and venue to suit the participant and were all undertaken by the first author, Jean Gilbert. On arrival at the interview, the information sheet was reviewed by the participant, they were then invited to sign a consent form. Following the interview, participants were offered an opportunity to ask questions or discuss any issues which may have arisen. The interviews were all audio-recorded and ranged in length from 60–90 minutes.

Analysis

The phases of thematic analysis outlined by Braun and Clarke [54] were used to conduct the analysis. Firstly, the data was transcribed verbatim and through this process the researcher became familiar with the data. The transcripts were read and re-read and initial ideas were noted. Coding of the data then took place which aimed to organise the data into meaningful groups [55]. Coding was performed using Nvivo software and after working through the entire data set making notes and highlighting potential patterns, a list of codes was generated. From the list of codes, a search for potential themes began where a thematic map was produced in order to ascertain what the main overarching themes were. Themes were then refined numerous times to determine a list of themes.

Results

Five overarching themes were identified which related to questions outlined by the interview schedule. The analysis is presented in response to the areas of questioning within the interview. In general, participants had some insight into compassion and its link to caring and trying to help individuals in distress.

Compassion to others

Relating to compassion towards other, discussion fell in to two distinct categories; people that participants felt compassionate towards and the type of compassion towards others that they described.

All participants felt they were compassionate to others. Ten participants reported they felt compassionate towards their spouse and children, one solely to their children, and one stated their parents. With regards to those participants felt compassionate towards they shared; "I suppose, they are the top of my list really as far as compassion goes", or that they were "very, very compassionate" towards others. Another lady found that by helping others "you're helping yourself at the same time" but stated that she "doesn't break down in floods of tears on a regular basis, I'm not that kind of person."

The key types of compassion that participants identified were talking or giving advice, listening and reassuring, physical contact (e.g. a hug), and practical support such as lending money.

In regards to reassurance when family members had problems they felt they would talk through the problems and help wherever possible, for example "I try to help as much as I can to put it right so they are not stressed." Talking and giving advice as a means of reassurance and compassion to others was reported eleven times by participants. This suggests talking and giving advice is perceived as essential by the participants in being compassionate towards others and as on participant stated "It's the simple things really".

Often their compassion was directed to their children and their children's' problems. One lady, whose daughter's husband had died suddenly, said, "Well I'd do anything for them …move in with them…we did actually move in for 3 months 'cos she'd got a little one 18 months old." This was reiterated by another participant who stated "whatever it needs to make it better".

They tried not to interfere with their families marital relationships and would "listen basically and just say keep your chin up, things will be better tomorrow". However, their family's problems would cause them distress. "In life children break your heart with their problems… I just think it's part of life and I just hope they get through it".

Another lady, however, felt, "I'm not one for sympathy… sympathy in itself isn't much good… you want some action you want to alleviate the problem… with sympathy, well anyone can just give sympathy."

Two participants spontaneously felt a hug was the first thing to do to reassure family members; "It's reassurance, giving them a hug and talking to them and saying don't worry we'll get over this", "She loves a hug, my youngest one," in this case physical reassurance was only provided for certain members of the family as she continued, "my eldest one is totally different, she's very very, sort of on her own really."

In regard to understanding the feelings of others and helping them cope with these feelings most of the responses were in the realm of talking through troubles and helping them "sort things out" and but mainly in "practical" ways. One subject stated openly that she did not "know about feelings. I don't do much at all with feelings because I think they're pretty level headed."

Compassion from others

Who?

Most participants stated that they had someone who they felt cared about them in some way and this generally consisted of family members; spouses, partners, children, parents and in-laws. Friends were not mentioned. Children were cited the most as a source of compassion with nine participants saying children; eight stated their spouse with four stating parents and three stating their sibling, notably female participants stating their brothers. There was however one participant who stated "I don't actually think there is anybody, even parents wise because I don't see them that much with things, you know.". One participant stated they 'see a shrink' because they don't receive compassion from anywhere else and that it feels as if they are "unloading all my troubles out of a bag and taking the empty bag out with me."

Responses to compassion

When asked how compassionate others were to them responses varied from "yes they really care about me" to "No I don't really think so." In particular, four people talked about compassion with some resistance and stated how they would rather deal with any problems themselves than share with others or receive help; "I say, "Yes I'm fine" because I don't want to upset them by saying I'm ill." "if I had got a problem they would try and help me as much as they could but I'm, I sort of, I tend not to sort of talk to other people." "I've learned to cope with my own strategies, to do it myself with things, you know." "but some things you just got to deal with, you know, you got to deal with yourself.".

Two subjects felt that their families could not pick up on their distress. One noted, "I probably try to hide it," and the other was sure that neither her husband nor her parents or children would know when she was distressed, especially when she did not want them to know she was upset. These individuals reported that their families were not there for them and that they did not receive compassion from them.

In terms of experiencing others expression of compassionate feelings for oneself, one participant suggested that "I think my wife deep down does but she's not one to show her feelings whereas I can, I would you know, but she would not." He continued saying that if something goes wrong and he tries to talk to her "she thinks you're having a go; so it's difficult in that situation…I've learned to cope on my own.". This suggests difficulties in receiving compassion due to availability.

However, this was not the case for five of the subjects who felt strongly that their families were there for them and would help them, again mostly practically, when necessary; "he makes me feel better when I've talked to him about it, whatever it might be. But he's always been there, always sort of understands."; "any problems and they're there right away, you know"; "I've only got to ask them if I need anything and they'd be there"; "yeah he does love me, I know that. He's always telling me that, every day, so."; "that's all I needed really [Yeh], a hug and a cup of tea and that's fine." These quotes highlight participants' awareness that they receive compassion in a variety of ways.

How others express compassionate

Of those who reported they felt others were compassionate towards them, compassion was described in a variety of ways. Practical support such as money or giving a lift were cited as compassion; "they are very compassionate but not, not, they don't go round sympathising, they go, er, 'do you want a lift somewhere; "I think sometimes it's just practical things cos often, you know, it depends if it's something like money". Being caring, listening and help in general were also considered as compassionate; "You don't have to do anything specific, you know if somebody cares about you."; "Yeah, they will listen and they always ask, you know, "Are you okay?" sort of thing,"; "But they are such a great help if, if the cards are on the table and things get rough, you know."

Encouragement, particularly around weight loss is viewed as compassion from others, at least by two participants; "my son's brilliant for trying to encourage

me….he wants to take me out on all these jogs and things …..and when I've got on the scales and lost two pounds he says that's brilliant but don't forget you're not cooking a lot today, no massive meals"; "encouraging me and saying how well I look and just to keep going and just encouraging really, yeah.". This suggests that compassionate acts mean different types of things to individuals.

Compassion to self

Six subjects felt that they were not self-compassionate. For example, "…..not very good at that"; "I don't suppose (I do it) enough really"; "honestly, probably I'm not very compassionate towards myself…no definitely not"; one lady even stated that "I'm not. I hate myself." This participant continued by saying that, "the way I look at it, if I hate myself then how can people 'like' me …..I am very compassionate friendly with them, I put myself out I mean my hours at work, it's four a day, I end up spending six hours a day there because …they haven't got enough staff so I feel sorry for them and I think well if I stay it might make them like me more, because I'm big you don't have many friends so you end up staying three hours extra a day…then they can't be judging me oh well she's just a fat person who likes sitting on her backside doing nothing…because I don't like myself I want to be able to hold my head up high and be proud of me".

One participant described how they have become more self-compassionate. One participant, who had been losing weight as part of a weight loss programme at a GP surgery felt that, "I think I am more compassionate towards myself in terms of in a practical way…before I lost…I was quite ambivalent about myself…it genuinely didn't bother me I was getting bigger and bigger…what I saw in the mirror I almost really didn't look that hard… it was more important to me to be able to eat what I wanted…I knew I was an unhealthy weight and that wasn't good for me. I overrode those feelings because it didn't bother me what I looked like…I think that was the problem why I didn't have a spur to diet. I think other people feel quite strongly about body image and feel a bit of self-disgust I didn't…I felt, if I'm honest that if I made the decision to lose weight I would do it. I knew I had the strength of personality to do it; I just didn't want to do it." It was only when her weight began to affect her health and stopped her doing the things she enjoyed that she decided to engage with a weight loss programme and she felt that now she was being far more compassionate towards herself.

Another participant felt that she was "alright now. I've learnt to love myself now but five years ago I didn't love myself and I was a gambler, I was a chronic gambler… someone told me at GA to stop betting, you've gotta like yourself first". This lady now feels she is compassionate towards herself and feels that 'by distancing herself from her family', being less enmeshed but taking short trips on her mobility scooter to see them. She felt it is important to have 'a little quiet time' and be able to unwind as a way of looking after herself.

When discussing what the participants did to help themselves when they were distressed, several stated that they used to eat but have stopped eating to cope with their distress as they were currently trying to lose weight. One lady stated that "I used to eat and I have to say that eating is quite nice still but long term it will make me feel more miserable." More recently therefore the subjects stated that they have changed their lifestyle so that they, they are now going to the gym, for a swim, a massage or a walk.

Compassion in childhood

All participants referred to some difficulties during childhood, mainly regarding family but some drew upon experiences at school, in particular with regards to being overweight. There was no specific abuse from parents or carers mentioned although some bullying from siblings and peers was. Problems from childhood varied. For example, some participants referred to problems of being one of too many children, especially coming from a poor background. One participant felt that she loved cooking and food and wondered if there was a link to the poverty in her young life and her present need to "make sure I have a stock of food in…to make sure you're never without food." These participants did feel that there was little compassion for them when growing up due to the issues of poverty, the arguments about money, and the fact the parents were so busy earning what money there was and that there was no time for them on an individual basis "you were swept along with the rest of the family."

Three participants had been only children. One participant felt, "I often got blamed for stuff I didn't even do." "Being wrongly accused was awful."

Another participant was born to parents in their late 30s. She was not allowed to go out to play with other children in the street. "I used to make my own games….I had all sort of toys and dolls and never went short of anything". However, at school she ended up feeling "a little bit out of it cos everybody else had got brothers and sisters and young parents and I didn't."

Three participants reported that their parents had got divorced and how this was "disruptive" due to the stigma attached to divorce at the time. All factors relating to family dynamics and experiences of compassion in childhood seemed to be underpinned by the absence of affection and time from parents. Four participants reported that due to their parents work commitments this limited time and affection available to them as children; in addition to this two participants stated they felt their

parents gave more time and affection to their siblings rather than to them. Due to this notion of compassion not being readily available from parents, a common theme, for eight participants was seeking compassion from elsewhere. Other sources of compassion discussed included aunts, grandparents, and communal support from a village. Food was also cited as a comfort by three participants.

Being overweight as a child did lead to bullying at secondary school. One participant had a method of dealing with bullying of this kind, "if anyone called me names I'd just turn round and belt them one because I could because I'd got the weight." But it did hurt and he would keep things to himself and felt he had ended up "being a loner."

Response to self-relapse

All participants were trying to lose weight in order to help with medical conditions. The participants from the Bariatric clinic had to show they could lose weight in order to have a gastric band or other forms of weight loss surgery. Therefore when initially asked how they would feel if they had put on weight the replies ranged from being disappointed to "absolutely repulsed with myself." In response to having compassion towards themselves during a relapse, one participant felt she would feel "mad rather than compassionate." Many participants had similar reactions, "I'd hate it, absolutely hate it….then because I'd feel angry I'd end up eating more, it wouldn't stop"; "pretty disgusted with myself because I think I've worked so hard to lose weight and I think I've radically changed my diet"; "Well you stupid idiot you shouldn't have done that….I'd start telling myself off."

Overall, one of the notable finding of this theme is just how hostile and how much self-hating goes on when individuals are trying to confront weight difficulties and struggle to lose weight or gain weight.

Response to relapse in others

Participants' responses were very different when they were asked to imagine a friend having a lapse in eating. Most of the participants felt they would try to motivate and encourage their friend, especially with practical advice on their eating habits, often making suggestions that had helped them personally. They appeared to understand the difficulties the other person was facing and would try to help them in any way they could. "I'd say to her 'right come on then girl let's sit down and do this together. You know it's important enough for you to get the weight off as well as me let's sit down let's do it together and we'll have a weigh in once a week together'… and I'd phone her…to make sure she hasn't cheated."

Only two participants were not so compassionate, "well I don't think I could because it's up to them and unless you take food away from them you can't help them"; "I would call them silly stupid…my friend whose diabetic…she's on dialysis…and I think she's having chocolate…and I tell her to her face…you're stupid then."

For the most part even though participants were self-hating in relation to their own weight problems, they articulated that they would not be like this with other people.

Discussion

There is increasing evidence that affiliative and compassionate processes can play a major role in coping with emotions and life difficulties and therefore can be therapeutic targets [35]. However little is known about how people actually understand and experience compassion, particularly in contexts of weight and obesity problems which can carry a lot of stigma and self-criticism. Hence this study set out to explore these experiences in people who are obese. On the whole we believe that the qualitative interview questions we developed were appropriate and helpful. Obviously subsequent researchers may wish to refine these questions. We would suggest that focusing on the fears of compassion could be a helpful addition.

Being compassionate to others

The results suggest that participants have a basic idea of compassion and its link to caring and trying to help individuals in distress. Participants felt that being compassion was about trying to be helpful, understanding and supportive of others when they are in distress, and was something they would want to do and tried to do. A variety of ways of doing this were suggested including: Offering hugs, listening and providing practical support and offering advice. For some participants it and wasn't clear if they tried to develop empathy and insight into the nature of people's difficulties or simply rushed into trying to be helpful. Some did acknowledge that because of their self-consciousness about their weight they would try to be extra helpful so that people would like them. This has been termed 'submissive compassion' (being nice to be liked) and is actually associated with *increased* vulnerability to depression and anxiety in a way that genuine compassion is not [56].

Compassion from others

Overall, some degree of compassion from others was reported by the majority of participants mostly from close family members It was expressed in the form of encouragement and praising of achievements when participants lost weight. It is unclear how much compassion was focused on participant's underlying emotional needs or states. It can be noted that few referred to friendships as a source of compassion, and indeed this was apparent throughout the transcripts. Although not directly assessed the interview had a sense that for many of these

participants there was a pervasive sense of loneliness partly linked to weight difficulties. Loneliness is known to be a major factor in all kinds of health problems [57].

The degree to which participants experienced compassion in childhood and the type compassion/caring they experienced is uncertain. We noted in the introduction that [47] distinguished between positively insightful, one-sided, and disengaged mothering. Our data are not sufficiently detailed to delve deeply into these distinctions, However, developing more precise measures to assess these dimensions of early caring may be valuable because 'one-sided caring', that may be practical but is not empathy based and leaves children with difficulties in working with emotions, allied with the use of food as emotion regulators, could be factors in later onset problems with eating. The point is that subsequent research on the early life experiences of compassion care need to be more detailed about exactly how that care was experienced and delivered.

Self-compassion

Although the participants have an understanding that when we struggle compassion is helpful, they were unable to apply this strategy to themselves. Indeed, participants felt that self-compassion was almost impossible, because when dealing with relapses they become self-hating and highly shaming. This mirrors findings in people with depression who also recognise the value of compassion but doubt that they could be compassionate to themselves, partly because of their condition. In their qualitative analysis of self-compassion in depression, Pauley and MacPherson [53] revealed comments like: "when I'm depressed, I just really, really don't like myself, so, there's no way that I'm going to feel compassion for myself;" "I don't think I'm really ever going to be able to do that"; and "when I feel depressed it's almost impossible to be forgiving towards myself, because when I feel depressed I think that it's my fault." It would seem that people with eating difficulties have the same difficulties with self-compassion.

Some participants felt that it was easiest to simply choose not to notice their weight difficulties and carry on eating as they wished. This is clearly a lack of self-compassion and insight into the need to genuinely 'looking after oneself'; perhaps more a form of denial and self-neglect but with consequences of potentially serious health problems.

We didn't investigate the fears of compassion but there was indirect evidence suggestions that individuals were fearful of receiving compassion and also taking the self compassionate orientation to themselves. This would be an important area to explore because of fears of compassion are linked to a range of emotion regulation difficulties [58,59]. Linked to this is the fact that people with severe weight problems do have difficulties in processing emotion including being aware of emotions in the body [14].

The issue of self-hatred has also been observed in people who have binge eating difficulties [33]. We think this is very important for a number of reasons. First, if individuals experience self-hating then they will be stimulating whole range of threat emotions which will need further regulation. Indeed there is evidence that self-criticism has major impact on the threat system processing as measured in fMRI studies and self-critical people can show threat response even when trying to be self compassionate [60]. Second, threat emotions and self-critical processes are actually associated with increased tendency to eat unhealthy food as noted in our introduction. Third it undermines hope and confidence that if one keeps trying things can change. Fourth self-hating interferes with adaptive problem-solving and impulse regulation and certainly does not activate the affiliative system that is important for down regulating threat processing [25].

Clinical implications

Compassion focused approaches have gained increasing evidence of their effectiveness [41]. Taken together, but mindful of the limited nature of this research, there are indications that this group of people have problems with compassion both receiving it from others but certainly being self-compassionate. Indeed, self-hatred dominates their presentations especially when they struggle with their weight. However, as noted in our introduction there is considerable evidence that self-criticism greatly accentuates mental health difficulties and problems with coping. So, in addition to dietary advice and learning emotion regulation and coping skills we suggest that specifically targeting self-criticism with a compassion focused intervention could be helpful and investigated. Indeed this has proved successful with eating disorders and other mental health problems [51]. We are currently exploring a specific programme for addressing shame and self-criticism with a large population of slimming world members. Preliminary evidence is showing very promising results.

Limitations

There are a number of limitations to the study. First it is a small exploratory study which would need to be replicated in larger populations. Nonetheless we think that the basis of the interview was successful as a starting place for this area of research. Second we didn't seek to explore gender differences this may be and could be taken up in subsequent research. A review of the literature, however, does not suggest any major gender differences in the areas that we were investigating. A third limitation in terms of general application is that individuals were seeking treatment from medical services and so may not be representative of the general obese or overweight population.

Future research

There would be opportunities for further research in this field; both qualitative and quantitative work. In terms of quantitative studies, the development of a measure or use of existing measures could be considered with this population. In terms of qualitative research, similar studies should be carried across other overweight or obese groups of people e.g. individuals attending weight loss clubs, individuals who do not actively want to lose weight. Specific demographic populations could also be studied e.g. differences between males and females and different ages. This may be useful in order to provide a broader picture the role of compassion and self-compassion has in people who are overweight.

Conclusion

This preliminary thematic analysis suggests that while participants saw compassion as related to 'caring' and being 'listened to' their recall of their own earlier experiences of compassion was limited to mainly practical help rather than emotional engagement. Many participants did not utilise compassionate strategies in response to their own relapse and setbacks but instead tended to view such events with self-criticism, self-disgust and self-hatred rather than self-caring or understanding. When people with weight problems relapse, or struggle to control their eating, they can become self-critical, even self-hating rather than self-compassionate. This profile of responses may increase difficulties with emotional coping, relapse prevention and maintenance of effective behaviour change. include mindfulness and compassion training could be helpful for these difficulties [51]. Future research should test the effectiveness of compassion-based interventions for relapse prevention and weight management.

Competing interests

JS is partly employed by Slimming World. All other authors declare that they have no competing interests.

Authors' contributions

JG, CG, JS and PG were involved in the design of the research. JG conducted the interviews. JG, CG, LD and LT were involved in coding and thematic analysis. JS, PG, LD and LT and CG drafted the manuscript. All authors read and approved the final manuscript.

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